

Santa Rosa Speech & Language Services  
John M. Samples, Ph.D., CCC-SLP & Kathryn Samples Williams, M.S. CCC-SLP  
3859 Montgomery Drive Santa Rosa, CA 95405

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Who referred you to this office?: \_\_\_\_\_

Who is your primary care doctor?: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_  
(Please provide your card for copying)

Secondary Insurance: \_\_\_\_\_  
(Please provide your card for copying)

**Authorization to Release Information**

I hereby authorize John M. Samples, Ph.D., CCC-SLP & Kathryn Samples Williams, M.S. CCC-SLP, to: (1) release any information necessary to insurance carriers regarding my treatment; (2) process insurance claims generated in the course of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from John M. Samples, Ph.D., CCC-SLP & Kathryn Samples Williams, M.S. CCC-SLP on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

**I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately unless previous arrangements have been made.** A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_